

TREATMENT DATA SYSTEM (TDS)

http://portalx.bisoex.state.me.us/pls/osa/tdsdev.main_menu_2.show

A-1 (Rev. 6/08)

AGENCY NAME / LOCATION

ADMISSION

A. DATE OF BIRTH												CLIENT CODE				B. LAST FOUR SS#				C. GENDER Check ONE box only		D. COUNTY OF RESIDENCE		E. FEDERAL IDENTIFIER CODE				F. CONTRACT NUMBER (Funded Agencies ONLY)									
MO		DAY		YEAR												<input type="checkbox"/> 01 MALE <input type="checkbox"/> 02 FEMALE																					
G. PRIMARY SERVICE CODE				H. DATE OF FIRST PHONE CALL				I. DATE OF FIRST FACE TO FACE CONTACT				J. DATE OF FIRST TREATMENT SESSION				K. PAYOR CODE																					
LIST G ON BACK				MO		DAY		YEAR		MO		DAY		YEAR		MO		DAY		YEAR		MO		DAY		YEAR		LIST K ON BACK									
1. HEALTH INSURANCE				2. REFERRAL		3. PRIOR TREATMENT EPISODES				4. ARE SPECIAL ACCOMMODATIONS NEEDED TO PROVIDE SERVICES?				5. RACE				6. ETHNICITY				7. VETERAN		8. EDUCATION COMPLETED													
MAY OR MAY NOT COVER ALCOHOL AND/OR DRUG TREATMENT <input type="checkbox"/> 01 PRIVATE INSURANCE <input type="checkbox"/> 02 BLUE CROSS/BLUE SHIELD <input type="checkbox"/> 03 MEDICARE <input type="checkbox"/> 04 MAINECARE (Medicaid) <input type="checkbox"/> 05 HEALTH MAINTENANCE ORGANIZATION (HMO) <input type="checkbox"/> 20 OTHER (e.g. Tricare, Champus) <input type="checkbox"/> 21 NONE				LIST 2 ON BACK		NUMBER OF PRIOR TREATMENT EPISODES IN ANY DRUG OR ALCOHOL TREATMENT PROGRAM Check ONE box only <input type="checkbox"/> 00 NONE <input type="checkbox"/> 01 ONE <input type="checkbox"/> 02 TWO <input type="checkbox"/> 03 THREE <input type="checkbox"/> 04 FOUR <input type="checkbox"/> 05 FIVE OR MORE				Check ONE box only YES NO <input type="checkbox"/> 01 <input type="checkbox"/> 02 (A) HEARING <input type="checkbox"/> 01 <input type="checkbox"/> 02 (B) VISUAL <input type="checkbox"/> 01 <input type="checkbox"/> 02 (C) PHYSICAL <input type="checkbox"/> 01 <input type="checkbox"/> 02 (D) LANGUAGE <input type="checkbox"/> 01 <input type="checkbox"/> 02 (E) OTHER				Check ONE box only <input type="checkbox"/> 01 WHITE <input type="checkbox"/> 02 BLACK OR AFRICAN AMERICAN <input type="checkbox"/> 03 AMERICAN INDIAN OR ALASKAN NATIVE <input type="checkbox"/> 04 ASIAN <input type="checkbox"/> 05 NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER <input type="checkbox"/> 99 OTHER				Check ONE box only <input type="checkbox"/> 01 NOT OF HISPANIC ORIGIN <input type="checkbox"/> 02 PUERTO RICAN <input type="checkbox"/> 03 MEXICAN <input type="checkbox"/> 04 CUBAN <input type="checkbox"/> 05 OTHER SPECIFIC HISPANIC <input type="checkbox"/> 06 HISPANIC SPECIFIC ORIGIN NOT SPECIFIED				Check ONE box only <input type="checkbox"/> 01 YES <input type="checkbox"/> 02 NO		HIGHEST GRADE COMPLETED													
9. CURRENT MARITAL STATUS				10-14. DEPENDENTS				15. IF THE CLIENT HAS DEPENDENT CHILDREN, WHERE ARE THE CHILDREN WHILE THE CLIENT WAS IN TREATMENT?				16. PREGNANT AT ADMISSION		17. IF PREGNANT, IS CLIENT RECEIVING PRE-NATAL CARE?		18. LIVING ARRANGEMENTS AT ADMISSION		19. EMPLOYMENT STATUS																			
Check ONE box only <input type="checkbox"/> 01 NEVER MARRIED <input type="checkbox"/> 02 NOW MARRIED/ COHAB <input type="checkbox"/> 03 SEPARATED <input type="checkbox"/> 04 DIVORCED <input type="checkbox"/> 05 WIDOWED				ENTER THE NUMBER OF DEPENDENT CHILDREN THE CLIENT HAS IN EACH AGE GROUP LISTED BELOW. 10 <input type="text"/> <input type="text"/> 0-12 MONTHS 11 <input type="text"/> <input type="text"/> 13-35 MONTHS 12 <input type="text"/> <input type="text"/> 3-5 YEARS 13 <input type="text"/> <input type="text"/> 6-12 YEARS 14 <input type="text"/> <input type="text"/> 13-17 YEARS				IF NO DEPENDENTS GO TO #16 Check ONE box only <input type="checkbox"/> 01 WITH THE CLIENT <input type="checkbox"/> 02 SPOUSE/OTHER PARENT <input type="checkbox"/> 03 GRANDPARENTS/RELATIVES <input type="checkbox"/> 04 FRIEND(S) <input type="checkbox"/> 05 BABYSITTER/CAREGIVER <input type="checkbox"/> 06 TEMPORARY FOSTER CARE <input type="checkbox"/> 99 OTHER				Check ONE box only <input type="checkbox"/> 01 YES <input type="checkbox"/> 02 NO IF NO, GO TO #18		Check ONE box only <input type="checkbox"/> 01 YES <input type="checkbox"/> 02 NO		Check ONE box only <input type="checkbox"/> 01 INDEPENDENT LIVING ALONE <input type="checkbox"/> 02 INDEPENDENT LIVING WITH OTHERS <input type="checkbox"/> 03 DEPENDENT LIVING <input type="checkbox"/> 04 HOMELESS		Check ONE box only <input type="checkbox"/> 01 FULL-TIME (35 HOURS OR MORE) <input type="checkbox"/> 02 PART-TIME (17-34 HOURS) <input type="checkbox"/> 03 IRREGULAR (LESS THAN 17 HOURS) <input type="checkbox"/> 04 UNEMPLOYED (HAS SOUGHT WORK) <input type="checkbox"/> 05 UNEMPLOYED (HAS NOT SOUGHT WORK) <input type="checkbox"/> 06 NOT IN LABOR FORCE <input type="checkbox"/> 07 FULL-TIME VOLUNTEER <input type="checkbox"/> 08 PART-TIME VOLUNTEER <input type="checkbox"/> 09 IRREGULAR VOLUNTEER																			
20. EMPLOYABILITY FACTOR (Check ONE box only)				21. HOUSEHOLD INCOME (LAST 30 DAYS)				22. PRIMARY SOURCE OF HOUSEHOLD INCOME/SUPPORT		23. SECONDARY SOURCE OF HOUSEHOLD INCOME/ SUPPORT IF DIFFERENT FROM PRIMARY		24. IS THE CLIENT NOW, OR HAS HE/SHE EVER BEEN A DOMESTIC VIOLENCE SURVIVOR?		25-28. TREATED FOR MEDICAL REASONS AT THE FOLLOWING LOCATIONS																							
<input type="checkbox"/> 01 EMPLOYABLE OR WORKING NOW <input type="checkbox"/> 02 STUDENT <input type="checkbox"/> 03 HOMEMAHER <input type="checkbox"/> 04 RETIRED <input type="checkbox"/> 05 UNABLE FOR PHYSICAL/ PSYCHOLOGICAL REASONS				<input type="checkbox"/> 06 INMATE OF INSTITUTION <input type="checkbox"/> 07 SEASONAL WORKER <input type="checkbox"/> 08 TEMPORARY LAYOFF <input type="checkbox"/> 09 UNABLE DUE TO SKILLS/RESOURCES <input type="checkbox"/> 10 UNABLE DUE TO PROGRAM REQUIREMENTS				ENTER AN AMOUNT BETWEEN 0003-9998 THAT REFLECTS HOUSEHOLD INCOME IN THE LAST 30 DAYS 0001 REFUSED 0002 UNKNOWN 9999 MORE THAN \$9999 \$ <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>				Check ONE box only <input type="checkbox"/> 01 YES <input type="checkbox"/> 02 NO		NUMBER OF TIMES TREATED FOR MEDICAL REASONS AT THESE LOCATIONS <input type="text"/> <input type="text"/> 25 PHYSICIANS OFFICE/CLINIC (LAST 12 MONTHS) <input type="text"/> <input type="text"/> 26 HOSPITAL EMERGENCY ROOM (LAST 12 MONTHS) <input type="text"/> <input type="text"/> 27 HOSPITAL INPATIENT (LAST 12 MONTHS) <input type="text"/> <input type="text"/> 28 OTHER (LAST 12 MONTHS)																							
29. MH/MR ISSUES DIAGNOSIS BASED ON DSM-IV		30-31. TREATED FOR MENTAL HEALTH ISSUES AT THE FOLLOWING LOCATIONS		32. CONSENT DECREE 1/1/89		33. PRIMARY PRESENTING PROBLEM		34-37. DRUGS USED INAPPROPRIATELY OR ABUSED BY CLIENT THAT LED TO ADMISSION		38-41. FREQUENCY OF USE OF DRUGS BY CLIENT IN LAST 30 DAYS		42-45. ROUTE OF ADMINISTRATION		46-49. AGE OF FIRST USE																							
Check ONE box only <input type="checkbox"/> 01 DIAGNOSED MENTAL ILLNESS/ DISORDER <input type="checkbox"/> 02 MENTAL RETARDATION <input type="checkbox"/> 00 NONE		NUMBER OF TREATMENT EPISODES AT THESE LOCATIONS <input type="text"/> <input type="text"/> 30 OUTPATIENT MENTAL HEALTH SERVICES (LAST 12 MO) <input type="text"/> <input type="text"/> 31 PSYCHIATRIC ADMISSIONS TO A HOSPITAL (LAST 2 YEARS)		Check ONE box only <input type="checkbox"/> 01 YES <input type="checkbox"/> 02 NO		Check ONE box only <input type="checkbox"/> 01 SUBSTANCE USE ABUSE <input type="checkbox"/> 02 AFFECTED/ CO-DEPENDENT <input type="checkbox"/> 03 EVALUATION ONLY IF AFFECTED CO-DEPENDENT ANSWER TOBACCO RELATED QUESTIONS (37, 41, 45, 49) THEN SKIP TO #52		<input type="text"/> <input type="text"/> <input type="text"/> 34 PRIMARY <input type="text"/> <input type="text"/> <input type="text"/> 35 SECONDARY <input type="text"/> <input type="text"/> <input type="text"/> 36 TERTIARY <input type="checkbox"/> 01 YES 37 TOBACCO <input type="checkbox"/> 02 NO Check ONE box only		<input type="text"/> <input type="text"/> 38 PRIMARY <input type="text"/> <input type="text"/> 39 SECONDARY <input type="text"/> <input type="text"/> 40 TERTIARY <input type="text"/> <input type="text"/> 41 TOBACCO		<input type="text"/> <input type="text"/> 42 PRIMARY <input type="text"/> <input type="text"/> 43 SECONDARY <input type="text"/> <input type="text"/> 44 TERTIARY <input type="text"/> <input type="text"/> 45 TOBACCO		<input type="text"/> <input type="text"/> 46 PRIMARY <input type="text"/> <input type="text"/> 47 SECONDARY <input type="text"/> <input type="text"/> 48 TERTIARY <input type="text"/> <input type="text"/> 49 TOBACCO																							
IF PRIMARY FREQUENCY (38) IS 02 COMPLETE #50 & #51, OTHERWISE, SKIP TO #52						52. INJECTION DRUG USE		53. IF CLIENT HAS USED NEEDLES, DID HE/SHE SHARE NEEDLES IN THE PAST YEAR?		54. MEDICATION ASSISTED TREATMENT		55. IS CLIENT CURRENTLY ATTENDING A SELF-HELP GROUP?		56. CURRENT LEGAL STATUS																							
50. INDICATE REASONS BEST DESCRIBING CLIENTS NON-USE IN THE 30 DAYS PRIOR TO ADMISSION				51. WHEN DID CLIENT LAST USE ALCOHOL AND/OR OTHER DRUGS?		Check ONE box only <input type="checkbox"/> 01 NEVER <input type="checkbox"/> 02 IN LAST 6 MONTHS <input type="checkbox"/> 03 IN LAST 12 MONTHS <input type="checkbox"/> 04 IN LAST 24 MONTHS <input type="checkbox"/> 05 IN LAST 5 YEARS <input type="checkbox"/> 06 MORE THAN 5 YEARS IF NEVER, GO TO QUESTION #54		Check ONE box only <input type="checkbox"/> 01 YES <input type="checkbox"/> 02 NO		Check ONE box only <input type="checkbox"/> 01 NO <input type="checkbox"/> 02 METHADONE <input type="checkbox"/> 03 LAAM <input type="checkbox"/> 04 BUPRENORPHINE/ SUBOXONE/ SUBUTEX <input type="checkbox"/> 05 CAMPRAL <input type="checkbox"/> 06 NALTARXONE <input type="checkbox"/> 07 VIVITROL <input type="checkbox"/> 08 ANTABUSE		Check ONE box only <input type="checkbox"/> 01 YES <input type="checkbox"/> 02 NO		List on back <input type="text"/> <input type="text"/>																							
57. DOMESTIC VIOLENCE OFFENDER		58. TOTAL NUMBER OF ARRESTS IN THE LAST 12 MONTHS		59. ARRESTS IN THE PRIOR 30 DAYS		60. OUI ARRESTS IN THE LAST 12 MONTHS		61. WILL CLIENT USE TREATMENT/ EVALUATION TO SATISFY DEEP REQUIREMENTS		62. DEEP STATUS		63. GLOBAL ASSESSMENT OF FUNCTIONING (GAF) SCALE		64. CLIENT AGREE TO A FOLLOW-UP																							
Check ONE box only <input type="checkbox"/> 01 YES <input type="checkbox"/> 02 NO								Check ONE box only <input type="checkbox"/> 01 YES <input type="checkbox"/> 02 NO <input type="checkbox"/> 99 AFFECTED/OTHER IF NO OR AFFECTED/OTHER GO TO QUESTION #63List		Check ONE box only <input type="checkbox"/> 01 FIRST OFFENDER <input type="checkbox"/> 02 MULTIPLE OFFENDER <input type="checkbox"/> 03 00 YOUTHFUL OFFENDER		ENTER THE APPROPRIATE LEVEL OF THE FUNCTIONING BASED ON THE GAF SCALE		Check ONE box only <input type="checkbox"/> 01 YES <input type="checkbox"/> 02 NO																							
DATE FORM COMPLETE		MO DAY YEAR		FORM COMPLETED BY		LAST NAME / FIRST		FORM EDITED BY		LAST NAME / FIRST																											

D. COUNTY CODES AN Androscoggin PT Penobscot AK Aroostook PS Piscataquis CD Cumberland SC Sagadahoc FN Franklin ST Somerset HK Hancock WO Waldo KC Kennebec WN Washington KX Knox YK York LN Lincoln OS Out of State OD Oxford OC Out of Country	18 EAP 19 SAP 20 State/Federal Court 21 Formal Adjudication Process/Maine Pre-Trial 22 Self-Help Group 23 Hospital 24 School 25 AIDS Outreach Worker 26 Community Probation, DSAT 27 Drug Court, DSAT 28 Network/JASAE 29 Juvenile Drug Court 99 Other	1206 Lorazepam (Ativan) 1207 Triazolam (Halcoïn) 1208 Other Benzodiazepine Other Tranquilizers 1301 Meprobarnate (Miltown) 1302 Other Tranquilizers Barbiturates 1401 Phenobarbital 1402 Secobarbital/Amobarbital (Tuinal) 1403 Secobarbital (Seconal) Other Sedatives and Hypnotics 1501 Ethchlorvynol (Placidyl) 1502 Glutethimide (Doriden) 1503 Methaqualone 1504 Other Non-Barbiturate Sedatives 1505 Other Sedatives 1506 Flunitrazepam (Rohypnol) 1507 GHB/GBL 1508 Ketamine (Special K) 1509 Clonazepam (Klonopin, Rivotril) Inhalants 1601 Aerosols 1602 Nitrites 1603 Other Inhalants 1604 Solvents 1605 Anesthetics Over the Counter 1700 Over the counter, General 1701 Diphenhydramine (Benadryl) Other 1801 Diphenylhydantoin Sodium (Phenytoin, Dilantin) 1802 Other Drugs
G. PRIMARY SERVICE CODES SUBSTANCE ABUSE/AFFECTED CLIENTS REHABILITATION / RESIDENTIAL 03 Hospital (Other than Detoxification) 04 Short Term (30 Days or Less) 05 Extended Care 06 Halfway House 07 Extended Shelter 15 Adolescent Res. Rehab. Transitional 44 Consumer Run Residence AMBULATORY 08 Non-Intensive Outpatient 11 Intensive Outpatient 12 Detoxification 13 Evaluation 18 Adolescent Outpatient 38 Adolescent Intensive Outpatient 40 Opioid Replacement Therapy	22-23. SOURCE OF HOUSEHOLD INCOME 00 None 01 Wages/Salary 02 Retirement 03 Alimony 04 Food Stamps 05 TANF 06 SSI 07 Disability, Other 08 Town Welfare 09 Child Support 10 Unemployment Benefits 11 Social Security 12 Dealing Drugs 13 Workers Compensation 99 Other/Investments	
K. PAYOR CODES 01 OSA 02 Human Services (other than child, adult protective) 03 Corrections 04 Human Services (child, adult protective) 05 Self-Pay 06 MaineCare (Medicaid) 07 Medicare 08 Blue Cross/Blue Shield 09 Health Maintenance Organization (HMO) 10 Other Private Health Insurance 11 Town Assistance 12 Workers Compensation 13 Veterans Administration 99 Other	34-36. SUBSTANCE CODES 0000 None Alcohol 0100 Alcohol Marijuana 0200 Marijuana Cocaine/Crack 0301 Cocaine 0302 Crack Heroin/Morphine 0400 Heroin/Morphine Methadone 0500 Methadone Buprenorphine 0550 Buprenorphine Other Opiates and Synthetics 0601 Codeine 0602 D-Propoxyphene 0603 Oxycodone (Percodan) 0604 Oxycontin 0605 Meperidine HCL 0606 Hydromorphone 0607 Other Narcotic Analgesics 0608 Pentazocine PCP 0700 PCP or PCP Combination Other Hallucinogens 0801 LSD 0802 Other Hallucinogens Methamphetamine/Speed 0900 Methamphetamine/Speed Other Amphetamines 1001 Amphetamine 1002 Methylphenidate (Ritalin) 1003 Methylenedioxymethamphetamine (MDMA, Ecstasy) Other Stimulants 1100 Other Stimulants Benzodiazepines 1201 Alprazolam (Xanax) 1202 Chlordiazepoxide (Librium) 1203 Clorazpate (Tranzene) 1204 Diazepam (Valium) 1205 Flurazepam (Dalmaine)	38-40. FREQUENCY OF USE 00 None (Cannot be used on #38) 02 No use past month 03 Once in last 30 days 04 2-3 days per/month 05 Once per week 06 2-3 days per/week 07 4-6 days per/week 08 Daily
2. PRIMARY REFERRAL SOURCE RESPONSIBLE FOR CLIENT BEING HERE 01 Self 02 Family Member 03 Employer 04 Substance Abuse Agency (Private Practice) 05 Substance Abuse Agency 06 Physician (Non-Substance Abuse Specialist) 07 Other Professional (Non-Substance Abuse Specialist) 08 DEEP (Driver Education/Evaluation Program) 09 Adult Protective Services, DHHS 10 Child Protective Services, DHHS 11 Substitute Care Services, DHHS 12 Probation/Parole, State of Maine 13 Correctional Facility, State of Maine 14 County Jails 15 Riverview Psychiatric Center/Bangor Mental Health Institute 16 Mental Health Agency 17 Friend (Continued in next column)	41. TOBACCO PRODUCTS ONLY (FOR USE WITH #41 ONLY) 00 None 10 About ½ pack/can/pouch a day 11 About 1 pack/can/pouch a day 12 About 1½ pack/can/pouch a day 13 About 2 packs/cans/pouches a day 14 More than 2 packs/cans/pouches a day 42-45. ROUTE OF ADMINISTRATION 00 Not Applicable (Cannot be used on #42) 01 Oral 02 Smoking 03 Inhalation 04 Injection 05 Other 56. CURRENT LEGAL STATUS CODES 00 No legal involvement 01 Probation/Parole 02 Furloughed 03 Awaiting Court 04 Serving Sentence (jail/prison) 05 Formal Adjudication 06 Driver's license revocation (NOT DEEP INVOLVED) 99 Other	